MAXIMUS Federal Services

Case Number:	CM14-0185032		
Date Assigned:	11/12/2014	Date of Injury:	04/03/2013
Decision Date:	12/15/2014	UR Denial Date:	10/06/2014
Priority:	Standard	Application Received:	11/05/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Orthopedic Surgeon and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 44-year-old male who reported an injury on 04/03/2013.The mechanism of injury was heavy lifting. His diagnoses include herniated nucleus pulposes at the L4-5 level, with right L5 radiculopathy. His past treatments include oral nonsteroidal anti-inflammatories, modified work duties, physical therapy, and 1 epidural steroid injection. The diagnostic studies include an MRI of the lumbar spine on 04/27/2013, which revealed a disc protrusion at L4-5, with foraminal herniation on the right side, L3-4 wide canal with factory (note in file states: facet) arthrosis, and L5-S1 small herniation. A repeat MRI of the lumbar spine was performed on 09/11/2014 and showed fairly well-maintained disc space. An EMG/NCV of the lower extremities was performed on 05/30/2013 and revealed a normal nerve conduction study with an abnormal electromyography. The EMG findings were suggestive of bilateral chronic active L4-5 radiculopathy that is greater on the right side than the left side. The past surgical history was not provided. On 11/06/2014, the injured worker presented with persistent low back pain with radiating pain into his right leg, calf, and foot that was worsened by activity. Objective findings revealed focal tenderness over the L3-4, L4-5, and L5-S1 posterior spinous processes and paravertebral muscles that were greater in the right side than the left side. He also had decreased range of motion in his lumbar spine; weakness in his right extensor Hallucis longus, gastric, and peroneal muscles; and a positive right straight leg raise. Current medications include ibuprofen, Midrin, and Norco. The treatment plan was noted to include moving forward with the authorized microscopic lumbar laminectomy and disc excision. A request was received for 2 to 4 days of postoperative inpatient hospital stay, the use of postoperative equipment, including a cold therapy unit, a front wheel walker, a 3 in 1 commode, and a shower chair. A rationale was not provided. A Request for Authorization form was submitted for review on 09/11/2014.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Associated surgical services: post-operative inpatient hospital days Quantity: 2-4: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Hospital length of stay (LOS).

Decision rationale: The request for associated surgical services: postoperative inpatient hospital days, quantity 2 to 4, is not medically necessary. The Official Disability Guidelines do recommend a hospital length of stay of 1 day following a lumbar spine laminectomy. The documentation submitted for review did indicate the injured worker to be recommended and approved for lumbar spine microscopic laminectomy and excision. However, the request is for 2 to 4 days hospital length of stay which is not supported by the evidence based guidelines. Therefore, the request for associated surgical services: postoperative inpatient hospital days, quantity 2 to 4, is not medically necessary.

Associated surgical services: post-operative cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Continuous-flow cryotherapy.

Decision rationale: The request for associated surgical services: postoperative cold therapy unit is not medically necessary. The Official Disability Guidelines recommend the use of a continuous-flow cryotherapy unit as an option after surgery for up to 7 days, including home use. The documentation submitted did indicate the injured worker was recommended and approved for lumbar spine microscopic laminectomy and excision. However, there was insufficient documentation to show if the surgery has been scheduled or performed. Therefore, in the absence of this documentation, the request is not supported by the evidence based guidelines. As such, the request for a postoperative cold therapy unit is not medically necessary.

Associated surgical services: post-operative front wheel walker: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Knee & leg

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Walking aids.

Decision rationale: The request for associated surgical services: post-operative front wheel walker is not medically necessary. The Official Disability Guidelines recommend walking aids to assist ambulation and reduce pain associated with knee osteoarthritis. There was insufficient documentation of treatment for a knee condition or a diagnosis of knee osteoarthritis. Additionally, there was no objective evidence of knee instability during the clinical visit in 11/2014. Therefore, in the absence of this documentation, the request is not supported by the evidence based guidelines. As such, the request for associated surgical services: post-operative front wheel walker is not medically necessary.

Associated surgical services: post-operative 3-in-1 commode: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Knee & Leg

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Durable medical equipment.

Decision rationale: The request for associated surgical services: post-operative 3-in-1 commode is not medically necessary. The Official Disability Guidelines recommend a 3-in-1 commode for patients with physical limitations resulting in bed or room confinement. There was insufficient documentation to show a postsurgical treatment plan indicating the injured worker will have physical limitations resulting in bed or room confinement. Moreover, there was insufficient documentation to show the surgery had been performed. Therefore, in the absence of this documentation, the request is not supported by the evidence based guidelines. As such, the request for associated surgical services: post-operative 3-in-1 commode is not medically necessary at this time.

Associated surgical services: post-operative shower chair: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Knee & Leg

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Durable medical equipment.

Decision rationale: The request for associated surgical services: post-operative shower chair is not medically necessary. The Official Disability Guidelines recommend a shower chair for patients with physical limitations resulting in bed or room confinement. There was insufficient documentation of a postsurgical treatment plan indicating the injured worker will have physical limitations resulting in bed or room confinement. Moreover, there was insufficient

documentation to show the surgery had been performed. Therefore, the request is not supported by the evidence based guidelines. As such, the request for associated surgical services: post-operative shower chair is not medically necessary.